TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Resources Fort Worth

Respondent Name
Phoenix Insurance Co

MFDR Tracking Number
M4-18-0837-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
November 28, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges, we also have attached this Rule. We realize these CT Scans have a Q3 status but they are not bundled per the NCCI edits and still should have had a reduced payment. The carrier also states 93306 is bundled into 99285, it is not per NCCI edits. We submitted an appeal but the carrier has denied all of our requests for a reconsideration."

Amount in Dispute: $1,369.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier denied reimbursement on the basis that the reimbursement for the diagnostic testing was included in reimbursement for the primary service rendered. As reimbursement for the disputed services are included on the reimbursement for the primary procedure rendered, the Provider is not entitled to separate services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 7 - 8, 2016	71010, 72125, 70450, 93306	$1,369.07	$1,369.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient hospital services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 4097 – Paid per fee schedule, charge adjusted because statute dictates allowance is greater than provider's charge
   - 4915 – The charge for the services represented by the revenue code are included/bundled info the total facility payment and do not warrant a separate payment or the payment status indicator the service is packaged or excluded from payment
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $1,369.07 for outpatient hospital services provided on December 7 -8, 2016. The specific codes in dispute are:
   - 71010 - Radiologic examination, chest; single view, frontal
   - 72125 - Computed tomography, cervical spine; without contrast material
   - 70450 - Computed tomography, head or brain; without contrast material
   - 93306 - Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography`

   The insurance carrier denied disputed services with carrier code 4915 – "The charge for the series represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment."

28 Texas Administrative Code §Rule 134.403 (d) states,

> For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

The applicable Medicare payment policy is found at www.cms.gov, The Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) which states in pertinent parts:

> *10.1.1 - An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule.*
>
> *10.2 - APC Payment Groups - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).*
>
> *10.2.1 - Composite APCs - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with*

multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Each of the above payment classifications are found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ in the Addendum.

Addendum B for 2016 indicates the following:

- Code 71010 has a status indicator of Q3
- Code 72125 has a status indicator of Q3
- Code 70450 has a status indicator of Q3
- Code 93306 has a status indicator of S

The definition of each status indicator is as follows:

Q3 - Codes That May Be Paid Through a Composite APC Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

Addendum M displays composite APC assignments when codes are paid through a composite APC.

(1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.

(2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.

S - Procedure or Service, Not Discounted When Multiple. Paid under OPPS; separate APC payment.

As the codes in dispute do not have status indicators that indicate "bundled, packaged or excluded," the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical bill finds separate reimbursement for implants was not requested. Therefore the services in dispute will be reviewed per 28 Texas Administrative Code 134.403 (f) (1) (A).

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Composite criteria met	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9618	40% non-labor related	Payment Medicare facility amount multiplied by 200%
71010	5521	Q3	No, paid separately	$60.80	$60.80 x 60% = $36.48	$36.48 x 0.9618 $35.069	$60.80 x 40% = $24.32	$35.09 + $24.32 = $59.41 x 200% = $118.82
72125	5570	Q3	Yes paid as composite 8005	$284.12	$284.12 x 60% = $170.47	$170.47 x 0.9618 = $163.96	$284.12 x 40% = $113.65	$163.96 + $113.65 = $277.61 x 200% = $555.22
70450	5570	Q3	Yes paid as composite 8005	Included in above				
93306	5533	S	n/a	$416.80	$416.80 x 60% = $250.80	$250.80 x 0.9618 = $240.53	$416.80 x 40% = $166.72	$240.53 + $166.72 = $407.25 x 200% = $814.50
							Total	$1,488.54

3. The total recommended reimbursement for the disputed services is $1,488.54. The insurance carrier paid $0.00. The requestor is seeking reimbursement of $1,369.07. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,369.07.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,369.07, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 21, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.